



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

OKLAHOMA SPINE HOSPITAL
C/O LARRY A BUNTING ATTORNEY AT LAW
3721 N CLASSEN BLVD
OKLAHOMA CITY OK 73118-2839

Respondent Name

LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box

Box Number 1

MFDR Tracking Number

M4-10-4710-01

MFDR Date Received

July 14, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I believe that Liberty Mutual is acting in bad faith by not properly paying the four (4) bills for medical treatment, after it had accepted the claim as compensable."

Amount in Dispute: \$42,069.81

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor has not justified its entitlement to further reimbursement and is therefore not due any further funds. The Requestor has waived its right to MDR by failing to file its dispute within one year of the dates of service at issue in this dispute."

Response Submitted by: Hanna & Plaut, LLP, Southwest Tower, 211 East 7th St., Ste. 600, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2008 to May 22, 2009	Inpatient Hospital Services	\$42,069.81	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE.
 - PA – FIRST HEALTH
 - P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)
 - X388 – PRE-AUTHORIZATION WAS REQUESTED BUT DENIED FOR THIS SERVICE PER DWC RULE 134.600. (X388)
 - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Are the disputed services subject to a contractual fee arrangement between the parties to this dispute?
3. Did the insurance carrier timely file the request for medical fee dispute resolution?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Oklahoma to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. The insurance carrier denied or reduced payment for disputed services with reason codes PA – "FIRST HEALTH"; and P303 – "THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 21, 2011, the Division requested additional information from the respondent pursuant to 28 Texas Administrative Code §133.307(e)(1), which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." The Division requested the respondent to provide a copy of the referenced contract(s) between the alleged network and Oklahoma Spine Hospital; a copy of the contract between Liberty Insurance Corporation and the alleged network; and documentation to support that Oklahoma Spine Hospital was notified in accordance with 28 Texas Administrative Code §133.4, effective July 27, 2008, 33 *Texas Register* 5701, applicable to services rendered between August 1, 2008 and December 31, 2010, that the insurance carrier had been granted access to the alleged contractual fee arrangement between the network and the health care provider. The respondent did not provide the requested information; therefore, this decision is based on the information available at the time of review. Review of the submitted information found no documentation to support a contract between the health care provider and the insurance carrier, nor any documentation to support a contractual fee arrangement between the health care provider and a network to which the insurance carrier had been granted access. The Division therefore concludes that the respondent has failed to support that the disputed services are subject to a contractual fee arrangement. Further, for the dates of service to which §133.4 is applicable, the Division finds that the insurance carrier has failed to meet the requirements of §133.4 and is not entitled to pay the health care provider at a contracted rate. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. 28 Texas Administrative Code §133.307(c)(1) states that "A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are from February 21, 2008 to May 22, 2009. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on July 14, 2010. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division does have jurisdiction to review this dispute, however, the requestor has waived the right to medical fee dispute resolution by failing to file a timely request for MDR of the disputed services. For that reason, the merits of the fee issues raised by either party to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 5, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.